

**Substance Use Guideline 1
PRINCIPLES OF PERINATAL CARE FOR SUBSTANCE
USING WOMEN AND THEIR NEWBORNS**

INTRODUCTION

The care of women and newborns with prenatal drug and alcohol exposure has been widely recognized as a significant health problem in British Columbia. Effective care for women who use substances and their newborns is multi-faceted, and involves the coordinated and collaborative teamwork of physicians, midwives, hospital nurses, hospital social workers, community health nurses, Ministry for Children and Families (MCF) child protection and family support workers, Aboriginal Child Welfare Agencies (ACWA) and other community based resources. These guidelines emphasize a continuum of care that begins in the antepartum period and extends into the neonatal period. This continuum of care provides a commitment to the provision of services in support of a woman, her infant and her family. A woman who is linked to appropriate resources can be effectively supported to work towards reducing or stopping her use of drugs (in the guidelines the terms “drugs” and “substance use” will be used to stand for all substances – alcohol and drugs).

The guidelines in this section of the *BCRCP Guidelines for Perinatal Care* manual include information on general principles, risks, clinical management of perinatal care for women substance users, discharge planning for mothers and their newborns, and clinical management specific to various drugs. While appropriate and effective prenatal care for substance using women is crucial, equally crucial is an effective and well-coordinated discharge plan to ensure system coordination and continuity of care. **Coordinated planning for the postnatal period should begin in advance of delivery, i.e. as soon as possible after a pregnant woman begins to seek prenatal care, and can be initiated by her health care provider(s) or other support services.** Because of the critical importance of effective discharge planning for substance using mothers and their infants, a separate guideline (Substance Use Guideline 2 – Discharge Planning Guide for Substance Using Women and Their Newborns) addresses this issue.

The development of the clinical management recommendations and the discharge plan was modeled on similar efforts undertaken by the creators of the Treatment Improvement Protocols (TIPS) at the United States Department of Health and Human Services in 1993. Two provincial documents: the FAS Strategic Plan (1993) and the FAS Community Action Guide (1998) were utilized, along with other resources.

GUIDELINE PRINCIPLES

- 1) All individuals, from a variety of social, economic, educational, racial and cultural backgrounds are at-risk for substance use during pregnancy.

- 2) It is important that women who are pregnant and using substances be informed by their health care and other service providers of their choices and rights at all steps of the process.
- 3) It is important to notice and highlight the strengths and protective factors of women, infants, their families, and their communities.
- 4) There is a continuum of help that can be offered to women, children and their families including health promotion, prevention and early intervention strategies, as well as appropriate treatment and follow-up supports. Harm reduction approaches for women and their families need to be encouraged also.
- 5) Optimal care is consistent with Integrated Case Management as outlined by the Ministry for Children and Families. This is defined as, “when the child...or adult has complex and often longer term needs that would require a formal and structured approach among service providers. This necessitates joint decision-making, development, implementation and monitoring of a single service plan and the clarification of their multiple roles and responsibilities. Each member of the integrated case management team must be clear about his/her part in the plan” (MCF, 1998). Integrated Case Management is a shared community process and should begin as soon as the pregnancy is known.
- 6) A recent study in B.C. showed that substance using women identified guilt and shame about their substance use along with fear of being judged as the biggest barriers to seeking treatment (Poole & Issac, 1998). This theme of guilt in pregnant substance users is well supported in the literature, and non-judgmental staff attitudes determining the success of treatment programs is also well supported (Burkett et al., 1998; Miller, 1998; Suffet & Brotman, 1984). A respectful approach acknowledges that change is a process and tries to meet the woman in the appropriate stage of change (Prochaska, 1998; Miller & Rollnick, 1991).
- 7) The completed Discharge Plan assumes the following:
 - Both mother and baby have been appropriately stabilized and managed from a medical perspective.
 - There is a plan in place to address any child protection concerns.
 - The referrals to the appropriate community supports have been made and are in place.
- 8) Maintaining the safety and well being of the infant is of fundamental importance. Ensuring that children are safe is a shared responsibility, and a collaborative team approach provides the best chance for reducing risk. However, only a fully delegated child protection social worker with the Ministry for Children and Families or with an Aboriginal Child Welfare Agency have the legal responsibility to assess when a child is in need of protection.

- 9) A collaborative team approach is needed to offer families help and support as early on as possible. When difficult decisions are required, a supportive team approach to decision making is optimal.
- 10) Preserving the mother-infant pair whenever possible is valuable. Helping to support women, children, and their families is the responsibility of all service providers including MCF & ACWA workers, as well as other family and community members, even during times when the mother and infant are separated.

EARLY COORDINATION AND PLANNING

It is essential that discharge planning begin during the prenatal period with the pregnant woman as outlined in Substance Use Guideline 2: Discharge Planning Guide for Substance Using Women and their Newborns. *Once the woman has consented to the exchange of information, all necessary health care providers, including physicians, as well as community based resources, should participate in an integrated case management process to coordinate their care. Advanced care planning should result in additional supports for the woman and allow her to play a key role in planning for both her and her newborn's care after delivery.*

The prenatal period is a time when a mother is most likely to engage with the health care team, so it is an ideal time to assess a mother's social situation and to engage her in positive planning for a healthy pregnancy and a healthy baby. Optimally, planning should be a coordinated effort, involving not only the health care team and the woman, but also supportive family members, community support agencies, and the Ministry for Children and Families or an Aboriginal Child Welfare Agency.

Health care providers (physicians and nurses), and other service providers, should encourage and assist patients with self-referral to the Ministry for Children and Families. Women and their families may resist involvement of the Ministry for Children and Families because they fear MCF removal of their child at birth. However, the mandate of MCF and ACPA includes offering of support either directly or through contracted agencies in situations where a social worker deems there is potential risk for a child. Early engagement with MCF will facilitate assessment and provision of service prior to delivery, as well as discharge planning after birth.

ENSURING THE WOMAN IS AWARE OF HER RIGHTS AND RESPONSIBILITIES

For the woman to participate in her own and her infant's care, she must be made aware of the rights and responsibilities of a parent within the complex medical-social system of British Columbia. It is essential therefore, that women are informed by health care and other service providers of the following information during the prenatal period:

- 1) Her right to confidentiality and its limits (harm to self or others, and subpoena).

- 2) Her right to ask questions and be involved in the planning of her own care and that of her fetus / newborn.
- 3) Her right to be provided accurate information about the risks of substance exposure during the perinatal period.
- 4) Her right to choice about her care.
- 5) Her right to access her medical records.
- 6) Her right to receive care provided in a manner free of economic, culturally biased, or racist assumptions.
- 7) Her right to know about Child Protection involvement following delivery.
- 8) The newborn child's right to be protected from abuse, neglect and harm or threat of harm.
- 9) Her, her family's, and the community's responsibility to ensure her newborn child is both protected from abuse, neglect, harm or threat of harm and cared for in a safe and nurturing environment.

INFORMATION SHARING BETWEEN HEALTH CARE PROVIDERS AND COMMUNITY REPRESENTATIVES

Requests for information between providers should always be accompanied by a written consent. Referrals involve an implied consent.

- 1) Any time a provider receives a request for information from another provider regarding a particular patient, it should be accompanied by the patient's written consent. In certain circumstances a verbal consent may be sufficient if the situation is urgent and the process is well documented. A written consent can always be forwarded at a later date.
- 2) Referrals from one provider to another are by the patient's request most often. Although there is no legislation governing this process, there is an implied consent that information will be shared between care providers unless otherwise specified by the client. Exceptions to this most often involve emergent situations where a person is unable to provide permission for referral on their own accord.

CONFIDENTIALITY

I PHYSICIANS

The Canadian Medical Association (CMA) Code of Ethics section 22 states that a physician must "respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when the maintenance of confidentiality would result in a significant risk of substantial harm to others ... in such cases, take all reasonable steps to inform the patient

that confidentiality will be breached” (CMA, 1997). In addition, physicians must report a child in need of protection in order to comply with The Child, Family and Community Services Act of BC (CFCS Act).

II EMPLOYEES OF HOSPITALS AND PUBLIC HEALTH CARE BODIES

Hospital and public health employees must also respect confidentiality however, information sharing can and must occur in certain circumstances. The collection and disclosure of information in the custody and control of a public body is governed by the *Freedom of Information and Protection of Privacy Act*. In this act, chart records and files are for the most part considered private information except when a request is made by a child protection social worker under Section 96 of the CFCS Act (see below).

REPORTING TO THE MINISTRY FOR CHILDREN AND FAMILIES

Under the law, all citizens of British Columbia are required to report to the Ministry for Children and Families any child who has been or is likely to be at risk for harm, neglect, or abuse. This act does not refer specifically to the situation of pregnancy, where there is not yet a child. Prior to birth a fetus is not considered a child or person under federal or provincial law. Physicians and nurses work under ethical guidelines emphasizing confidentiality and consent. In providing care to substance using women during pregnancy, before the child is born, they may face a decision about breaching these principles because of potential risk for that child.

There are a number of views among practitioners and between practitioners and child protection authorities regarding the duty of a health care provider (physician or nurse) to make a report to the Ministry for Children and Families about a pregnant woman whose substance use puts herself and her fetus at risk.

Health care providers work within ethical guidelines emphasizing confidentiality and consent, and the requirement to work at all times in the best interests of the patient. They must develop a trusting relationship in order to support the capacity of a pregnant woman to enhance her health by participating in optimal prenatal care, any necessary treatments, and advance care planning. The provider may be concerned that making an antenatal referral or report to MCF without the woman’s consent will undermine the therapeutic relationship necessary for reducing medical risk for both the pregnant woman and her fetus. In other words, a provider whose patient chooses not to engage with MCF, and who refuses consent for release of information, must decide whether making a report will increase risk to both the mother and her fetus, and must determine what his/her legal and ethical responsibilities are.

It is the opinion of many experienced practitioners that their best chance of assisting their patient to reduce risk is to work in partnership with her, enhancing her capacity to control substance use and to access the supports she needs.

The Child, Family and Community Services Act of BC (sections 13 and 14) define the circumstances under which a child may need protection, and the duty of every person to report to a Ministry for Children and Families child protection social worker knowledge of a child in those circumstances. Section 13 states that a child needs protection when (s)he has been or is likely to be subject to:

- 1) Physical harm
- 2) Sexual abuse
- 3) Sexual exploitation
- 4) Emotional harm
- 5) Deprivation of required health care
- 6) Parental refusal of needed treatment for the child
- 7) Inadequate provision for the child's care
- 8) Child's prolonged absence from home in dangerous circumstances
- 9) Death of the parent or abandonment with inadequate provision for the child's care.

Section 14 states that any person with reason to believe that a child is in need of protection must promptly report the situation to a child protection social worker. The legislation defines a child as a person under 19 years of age. However, no section of the CFCS Act specifically refers either to pregnancy or reporting a fetus at risk. Under Canadian law, a fetus is not considered to be a person.

It is the position of the Ministry for Children and Families Child Protection Division (which operates under the CFCS Act mandate) that health providers should report to a child protection worker when there is reason to believe that an unborn child may at birth need protection. However, the legislation does not provide for delegated child protection social workers to take any protective action until a child is born. On the other hand, waiting until the child is born before engaging the mother with MCF leaves the child protection social worker with very little time to complete a full and appropriate assessment.

Therefore, health providers will sometimes face the responsibility of making a choice between their duty of care to a pregnant woman and their understanding of the conflicting opinions about the duty under the CFCS Act to report antenatally that a child may be in need of protection at birth. Health care providers and other support services must work closely together, and with the woman herself, to ensure the best possible outcome for both her and her infant. Practitioners will need to consider each case carefully, and apply their best judgement when deciding on the appropriate course of action. The key issue is to ensure that child protection concerns are addressed once the child is born.

INFORMATION SHARING FOLLOWING A REPORT TO THE MINISTRY FOR CHILDREN AND FAMILIES

Once a child is born and if a report is made regarding that child's safety, the Ministry for Children and Families must investigate that child's need for protection. The investigating social worker may need to obtain additional information from health providers. The

proper process for obtaining further information (described in the Freedom of Information and Protection of Privacy Act) depends on whether the information sought is in the custody or control of a public body. Generally, hospital and public health records are in the custody and control of a public body, but private physician's records are not.

I PHYSICIANS

Once a report has been made to the MCF, the documentation of the concern and other information in the physician's chart are again subject to physician/patient confidentiality requirements. Therefore, the documentation can only be provided:

- 1) with the patient's written consent, or
- 2) pursuant to a court order under section 65 of the CFCS Act, or
- 3) in situations where *maintenance of confidentiality would result in a significant risk of substantial harm to others...* (CMA Code of ethics section 22)

II EMPLOYEES OF HOSPITALS AND PUBLIC HEALTH CARE BODIES

During an investigation, the Ministry for Children and Families has the right to access hospital and public health information and documents regarding a mother and her child under the Freedom of Information and Protection of Privacy Act. This is clearly stated in section 96 of the CFCS Act titled: the *Director's right to information*. Under this provision, child protection social workers have the right to request information necessary for them to do their job. Requests for information should be in writing (unless an emergency makes this impractical), should state the legal authority for requesting the information, and should confirm the authority of the person making the request. The request should be forwarded to a specified representative within the receiving organization. It is important to learn who this representative is within your organization and to consult with them before responding to any requests.

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